STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155782	A. BUILDING _____ B. WING _____	C 09/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK HEALTH CAMPUS	**814 S 6TH ST MONTICELLO, IN 47960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the investigation of complaint number IN00095727. Complaint Number IN00095727 Unsubstantiated due to lack of evidence Survey Date: September 9, 2011 Facility Number: 012355 Provider Number: 155782 AIM Number: 201014410 Survey Team: Linda Campbell, RN Census Bed Type: SNF: 28 SNF/NF: 9 Residential: 35 Total: 72 Census Payor Type: Medicare: 22 Medicaid: 7 Other: 43 Total: 72 Sample: 3 White Oaks Health Campus was found to be in compliance with 42 CFR part 483, Subpart B and 410 IAC 16.2 in regard to the investigation of complaint number IN00095727. Quality review completed 9/9/11 Cathy Emswiller RN	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE